

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4767

CERTIFICATE OF DEATH

Reg. Dist. No.

04749

261-

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Ann</u> Last <u>Byrd</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sea food</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Parksley, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Edward Drummond</u>		14. MOTHER'S MAIDEN NAME <u>Mary Emily Abbot</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not known) <u>No.</u>		16. SOCIAL SECURITY NO. <u>219-07-1302</u>	
17. INFORMANT <u>Sarah Jane Byrd - Marion Sta., MD</u>		Address <u>206</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lungs -</u> DUE TO (c) <u>Venous Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 or 20 min</u> <u>1st seen Jan 3 - 1959</u> <u>" " "</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 3, 1959</u> , to <u>Apr. 1, 1959</u> , that I last saw the deceased alive on <u>Mar. 28, 1959</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George C. Coulbourn</u> M.D.		ADDRESS (Street, city or town, state) <u>MARION STATION - MD - 4-4-59</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>George C. Coulbourn MD - Marion Sta. MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Byrd Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marion Sta., Som. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward - Marion Sta., MD. 235</u>		24a. REC'D BY REGISTRAR DATE <u>APR 8 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

CERTIFICATE OF DEATH

1957

Name of Deceased George Forward		Sex Male	
Date of Birth 11-2-1882		Place of Birth Maryland	
Date of Death 11-2-1957		Place of Death Baltimore, Maryland	
Cause of Death Heart Disease		Manner of Death Natural	
Physician's Name Dr. J. H. Smith		Hospital or Place of Care St. Mary's Hospital	
Signature of Physician J. H. Smith		Signature of Registrar J. H. Smith	
Date of Certificate 11-2-1957		Place of Issuance Baltimore, Maryland	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7, Film G241, 4/10/59 for
4768
CERTIFICATE OF DEATH

04750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRMOUNT,		c. LENGTH OF STAY IN b 35 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAN Middle COLEMAN Last COLEMAN		4. DATE OF DEATH Month 4 Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE C OLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Farm Labor	
11. BIRTHPLACE (State or foreign country) WEST Virginia		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME ??		14. MOTHER'S MAIDEN NAME ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ANNIE GILES. POCOMOKE CITY, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 15th 1957 to March 4, 1959 , that I last saw the deceased alive on March 3rd 1959 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Edson G. Mautman M.D. Princess Anne, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/7/59	
22c. NAME OF CEMETERY OR CREMATORY CRIST M.E.		22d. LOCATION (City, town, or county) (State) PUNCH LANDEN MD	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR		ADDRESS PRINCESS ANNE, MD	
24a. REC'D BY REGISTRAR APR 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thang	

W. H. R. O. M. D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04751

Reg. Dist. No.

4769

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MtVernon	c. LENGTH OF STAY IN 1b Life	X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne R.F.D (MtVernon), Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Lewis Donald Collins		4. DATE OF DEATH Month April Day 8 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1927
9. AGE (in years last birthday) 31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) MtVernon Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A			
13. FATHER'S NAME Arthur G. Collins		14. MOTHER'S MAIDEN NAME Ina B. Donald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-22-7258	
17. INFORMANT Ina B. Collins Princess Anne R.F.D 2,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Twenty two rifle bullet into heart 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted rifle shot into heart	
20c. TIME OF INJURY Month, Day, Year 6:15 p. m. 4-8 19 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Near home	20f. (City or town) (County) (State) MtVernon Somerset Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R. H. Johnson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. H. Johnson, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/11/59	
22c. NAME OF CEMETERY OR CREMATORY Ashbury		22d. LOCATION (City, town, or county) (State) MtVernon Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Herman Princess Anne Md</i>		24a. REC'D BY REGISTRAR APR 13 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7, Film G241, 4/16/59 fcy

CERTIFICATE OF DEATH

04752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 62 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALDEN C DIZE		4. DATE OF DEATH APRIL 9 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-9-1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRY CLEANER		10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME L. COOPER DIZE		14. MOTHER'S MAIDEN NAME PHOEBE WARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. CLINTON DIZE	
17. INFORMANT CLINTON DIZE		Address CRISFIELD, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetic Arteriosclerosis & Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Vascular Accident - 2 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/25 , 19 52 to 4/9 , 19 59 , that I last saw the deceased alive on 4/8 , 19 59 , and that death occurred at 5:45 A.M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND DATE SIGNED 4/9/59			
ACTUAL SIGNATURE A. N. Barr M.D.			
PHYSICIAN'S NAME (Type) A. N. BARR, M.D. CRISFIELD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-59	
22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.		ADDRESS	
24a. REC'D BY REGISTRAR APR 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Pratt	

4763

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 127 Maryland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle WILLIAM Last GOLDSBOROUGH		4. DATE OF DEATH Month April Day 21 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1913
9. AGE (In years last birthday) yrs. 45		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (State or foreign country) Crisfield, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert H. Goldsborough	
14. MOTHER'S MAIDEN NAME Ella Kelly		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	
16. SOCIAL SECURITY NO. 216-05-3761		17. INFORMANT Address Mrs. Frances Goldsborough, Crisfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 3 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 21, 1959 to April 21, 1959 , that I last saw the deceased alive on April 21, 1959 , and that death occurred at 6 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 334 Main St - Crisfield, Md. 4/22/59			
ACTUAL SIGNATURE Sarah M. Peyton M.D.		PHYSICIAN'S NAME (Type) Sarah M. Peyton, Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-24-59	22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.		24a. REC'D BY REGISTRAR DATE APR 24 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hana

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

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VS A15 (4)
15M 9/58

00773

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4764

CERTIFICATE OF DEATH

04754

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>		c. LENGTH OF STAY IN TB <u>LIFETIME</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 CRISFIELD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>AT HOME</u>				d. STREET ADDRESS <u>ASBURY DISTRICT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NANCY</u> Middle <u>M.</u> Last <u>GOLDSBOROUGH</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 27 - 1860</u>	9. AGE (In years last birthday) <u>98</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEHOLD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID M. NELSON</u>				14. MOTHER'S MAIDEN NAME <u>JULIA MCCREADY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs Mayme Powell - Salisbury Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic Myocarditis</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>25 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Degeneration. Inanition</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>May 26</u> , 19 <u>53</u> , to <u>April 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>59</u> , and that death occurred at <u>11:40 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. N. Barr, M.D.</u>		M.D.		ADDRESS (Street, city or town, state) <u>Crisfield, Maryland</u>		DATE SIGNED <u>4/13/59</u>	
PHYSICIAN'S NAME (Type) <u>A. N. BARR, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-13-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NELSON FAMILY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CRISFIELD MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Webster</u>				ADDRESS <u>Crisfield Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carsten L. Knapp</u>			

4771

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manokin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manokin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>J.</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14, 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Wilmington, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Spearman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bostic</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>220-03-8426</u>	
17. INFORMANT <u>Edwinz Britts - 39 John St. Providence R.I.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>March 11, 1929</u> to <u>APR 8, 1929</u> , that I last saw the deceased alive on <u>APR 7, 1929</u> , and that death occurred at <u>4:17 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edmon G. Marksman M.D.</u> <u>Princess Annema H/8/59</u> PHYSICIAN'S NAME (Type) <u>Edmon G. Marksman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/12/59</u>	<u>Family Cemetery</u>	<u>Manokin, Som. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward - Marion St., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Armed & House</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4772

CERTIFICATE OF DEATH

04755

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Somerset</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Ann</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Linden Avenue</u>		d. STREET ADDRESS <u>Linden Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>E.</u> Last <u>Handy</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24 1874</u>
9. AGE (In years last birthday) yrs. <u>84</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willman Handy</u>		14. MOTHER'S MAIDEN NAME <u>Notknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>S.A.W.</u> <u>W.W.1.</u>		16. SOCIAL SECURITY NO. <u>Nettie V. Handy Princess Ann. Box 312</u>	
17. INFORMANT <u>Nettie V. Handy Princess Ann. Box 312</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> <u>431X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 13th</u> 19 <u>59</u> , to <u>Apr 14</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Apr 13</u> 19 <u>59</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Edison G. Markisoman M.D. Princess Anne, Md.</u>			
ACTUAL SIGNATURE <u>Edison G. Markisoman</u>			
PHYSICIAN'S NAME (Type) <u>Edison G. Markisoman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Turkey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		ADDRESS <u>Salisbury Md</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hana</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STAIN BOND

OF THE
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

4752

1972

1. NAME OF DECEASED <u>JOHN J. BROWN</u>		2. SEX <u>Male</u>		3. AGE <u>68</u>	
4. DATE OF DEATH <u>10-15-72</u>		5. TIME OF DEATH <u>10:30 AM</u>		6. PLACE OF DEATH <u>Home</u>	
7. CAUSE OF DEATH <u>Myocardial Infarction</u>		8. MANNER OF DEATH <u>Natural</u>		9. PLACE OF BIRTH <u>Baltimore, Md.</u>	
10. OCCUPATION <u>Retired</u>		11. MARITAL STATUS <u>Married</u>		12. EDUCATION <u>High School</u>	
13. PREVIOUS ILLNESS <u>None</u>		14. PRESENT ILLNESS <u>None</u>		15. MEDICAL HISTORY <u>None</u>	
16. SIGNATURE OF DECEASED <u>John J. Brown</u>		17. SIGNATURE OF WITNESS <u>John J. Brown</u>		18. SIGNATURE OF PHYSICIAN <u>John J. Brown</u>	
19. SIGNATURE OF CORONER <u>John J. Brown</u>		20. SIGNATURE OF JURY <u>John J. Brown</u>		21. SIGNATURE OF JUDGE <u>John J. Brown</u>	
22. SIGNATURE OF CLERK <u>John J. Brown</u>		23. SIGNATURE OF NOTARY <u>John J. Brown</u>		24. SIGNATURE OF SHERIFF <u>John J. Brown</u>	
25. SIGNATURE OF DEPUTY SHERIFF <u>John J. Brown</u>		26. SIGNATURE OF JAILER <u>John J. Brown</u>		27. SIGNATURE OF WARDEN <u>John J. Brown</u>	
28. SIGNATURE OF CHIEF OF POLICE <u>John J. Brown</u>		29. SIGNATURE OF DETECTIVE <u>John J. Brown</u>		30. SIGNATURE OF OFFICER <u>John J. Brown</u>	
31. SIGNATURE OF SGT. <u>John J. Brown</u>		32. SIGNATURE OF CAPT. <u>John J. Brown</u>		33. SIGNATURE OF MAJOR <u>John J. Brown</u>	
34. SIGNATURE OF LIEUT. <u>John J. Brown</u>		35. SIGNATURE OF 1ST LT. <u>John J. Brown</u>		36. SIGNATURE OF 2ND LT. <u>John J. Brown</u>	
37. SIGNATURE OF 3RD LT. <u>John J. Brown</u>		38. SIGNATURE OF 4TH LT. <u>John J. Brown</u>		39. SIGNATURE OF 5TH LT. <u>John J. Brown</u>	
40. SIGNATURE OF 6TH LT. <u>John J. Brown</u>		41. SIGNATURE OF 7TH LT. <u>John J. Brown</u>		42. SIGNATURE OF 8TH LT. <u>John J. Brown</u>	
43. SIGNATURE OF 9TH LT. <u>John J. Brown</u>		44. SIGNATURE OF 10TH LT. <u>John J. Brown</u>		45. SIGNATURE OF 11TH LT. <u>John J. Brown</u>	
46. SIGNATURE OF 12TH LT. <u>John J. Brown</u>		47. SIGNATURE OF 13TH LT. <u>John J. Brown</u>		48. SIGNATURE OF 14TH LT. <u>John J. Brown</u>	
49. SIGNATURE OF 15TH LT. <u>John J. Brown</u>		50. SIGNATURE OF 16TH LT. <u>John J. Brown</u>		51. SIGNATURE OF 17TH LT. <u>John J. Brown</u>	
52. SIGNATURE OF 18TH LT. <u>John J. Brown</u>		53. SIGNATURE OF 19TH LT. <u>John J. Brown</u>		54. SIGNATURE OF 20TH LT. <u>John J. Brown</u>	
55. SIGNATURE OF 21ST LT. <u>John J. Brown</u>		56. SIGNATURE OF 22ND LT. <u>John J. Brown</u>		57. SIGNATURE OF 23RD LT. <u>John J. Brown</u>	
58. SIGNATURE OF 24TH LT. <u>John J. Brown</u>		59. SIGNATURE OF 25TH LT. <u>John J. Brown</u>		60. SIGNATURE OF 26TH LT. <u>John J. Brown</u>	
61. SIGNATURE OF 27TH LT. <u>John J. Brown</u>		62. SIGNATURE OF 28TH LT. <u>John J. Brown</u>		63. SIGNATURE OF 29TH LT. <u>John J. Brown</u>	
64. SIGNATURE OF 30TH LT. <u>John J. Brown</u>		65. SIGNATURE OF 31ST LT. <u>John J. Brown</u>		66. SIGNATURE OF 32ND LT. <u>John J. Brown</u>	
67. SIGNATURE OF 33RD LT. <u>John J. Brown</u>		68. SIGNATURE OF 34TH LT. <u>John J. Brown</u>		69. SIGNATURE OF 35TH LT. <u>John J. Brown</u>	
70. SIGNATURE OF 36TH LT. <u>John J. Brown</u>		71. SIGNATURE OF 37TH LT. <u>John J. Brown</u>		72. SIGNATURE OF 38TH LT. <u>John J. Brown</u>	
73. SIGNATURE OF 39TH LT. <u>John J. Brown</u>		74. SIGNATURE OF 40TH LT. <u>John J. Brown</u>		75. SIGNATURE OF 41ST LT. <u>John J. Brown</u>	
76. SIGNATURE OF 42ND LT. <u>John J. Brown</u>		77. SIGNATURE OF 43RD LT. <u>John J. Brown</u>		78. SIGNATURE OF 44TH LT. <u>John J. Brown</u>	
79. SIGNATURE OF 45TH LT. <u>John J. Brown</u>		80. SIGNATURE OF 46TH LT. <u>John J. Brown</u>		81. SIGNATURE OF 47TH LT. <u>John J. Brown</u>	
82. SIGNATURE OF 48TH LT. <u>John J. Brown</u>		83. SIGNATURE OF 49TH LT. <u>John J. Brown</u>		84. SIGNATURE OF 50TH LT. <u>John J. Brown</u>	
85. SIGNATURE OF 51ST LT. <u>John J. Brown</u>		86. SIGNATURE OF 52ND LT. <u>John J. Brown</u>		87. SIGNATURE OF 53RD LT. <u>John J. Brown</u>	
88. SIGNATURE OF 54TH LT. <u>John J. Brown</u>		89. SIGNATURE OF 55TH LT. <u>John J. Brown</u>		90. SIGNATURE OF 56TH LT. <u>John J. Brown</u>	
91. SIGNATURE OF 57TH LT. <u>John J. Brown</u>		92. SIGNATURE OF 58TH LT. <u>John J. Brown</u>		93. SIGNATURE OF 59TH LT. <u>John J. Brown</u>	
94. SIGNATURE OF 60TH LT. <u>John J. Brown</u>		95. SIGNATURE OF 61ST LT. <u>John J. Brown</u>		96. SIGNATURE OF 62ND LT. <u>John J. Brown</u>	
97. SIGNATURE OF 63RD LT. <u>John J. Brown</u>		98. SIGNATURE OF 64TH LT. <u>John J. Brown</u>		99. SIGNATURE OF 65TH LT. <u>John J. Brown</u>	
100. SIGNATURE OF 66TH LT. <u>John J. Brown</u>		101. SIGNATURE OF 67TH LT. <u>John J. Brown</u>		102. SIGNATURE OF 68TH LT. <u>John J. Brown</u>	
103. SIGNATURE OF 69TH LT. <u>John J. Brown</u>		104. SIGNATURE OF 70TH LT. <u>John J. Brown</u>		105. SIGNATURE OF 71ST LT. <u>John J. Brown</u>	
106. SIGNATURE OF 72ND LT. <u>John J. Brown</u>		107. SIGNATURE OF 73RD LT. <u>John J. Brown</u>		108. SIGNATURE OF 74TH LT. <u>John J. Brown</u>	
109. SIGNATURE OF 75TH LT. <u>John J. Brown</u>		110. SIGNATURE OF 76TH LT. <u>John J. Brown</u>		111. SIGNATURE OF 77TH LT. <u>John J. Brown</u>	
112. SIGNATURE OF 78TH LT. <u>John J. Brown</u>		113. SIGNATURE OF 79TH LT. <u>John J. Brown</u>		114. SIGNATURE OF 80TH LT. <u>John J. Brown</u>	
115. SIGNATURE OF 81ST LT. <u>John J. Brown</u>		116. SIGNATURE OF 82ND LT. <u>John J. Brown</u>		117. SIGNATURE OF 83RD LT. <u>John J. Brown</u>	
118. SIGNATURE OF 84TH LT. <u>John J. Brown</u>		119. SIGNATURE OF 85TH LT. <u>John J. Brown</u>		120. SIGNATURE OF 86TH LT. <u>John J. Brown</u>	
121. SIGNATURE OF 87TH LT. <u>John J. Brown</u>		122. SIGNATURE OF 88TH LT. <u>John J. Brown</u>		123. SIGNATURE OF 89TH LT. <u>John J. Brown</u>	
124. SIGNATURE OF 90TH LT. <u>John J. Brown</u>		125. SIGNATURE OF 91ST LT. <u>John J. Brown</u>		126. SIGNATURE OF 92ND LT. <u>John J. Brown</u>	
127. SIGNATURE OF 93RD LT. <u>John J. Brown</u>		128. SIGNATURE OF 94TH LT. <u>John J. Brown</u>		129. SIGNATURE OF 95TH LT. <u>John J. Brown</u>	
130. SIGNATURE OF 96TH LT. <u>John J. Brown</u>		131. SIGNATURE OF 97TH LT. <u>John J. Brown</u>		132. SIGNATURE OF 98TH LT. <u>John J. Brown</u>	
133. SIGNATURE OF 99TH LT. <u>John J. Brown</u>		134. SIGNATURE OF 100TH LT. <u>John J. Brown</u>		135. SIGNATURE OF 101ST LT. <u>John J. Brown</u>	
136. SIGNATURE OF 102ND LT. <u>John J. Brown</u>		137. SIGNATURE OF 103RD LT. <u>John J. Brown</u>		138. SIGNATURE OF 104TH LT. <u>John J. Brown</u>	
139. SIGNATURE OF 105TH LT. <u>John J. Brown</u>		140. SIGNATURE OF 106TH LT. <u>John J. Brown</u>		141. SIGNATURE OF 107TH LT. <u>John J. Brown</u>	
142. SIGNATURE OF 108TH LT. <u>John J. Brown</u>		143. SIGNATURE OF 109TH LT. <u>John J. Brown</u>		144. SIGNATURE OF 110TH LT. <u>John J. Brown</u>	
145. SIGNATURE OF 111TH LT. <u>John J. Brown</u>		146. SIGNATURE OF 112TH LT. <u>John J. Brown</u>		147. SIGNATURE OF 113TH LT. <u>John J. Brown</u>	
148. SIGNATURE OF 114TH LT. <u>John J. Brown</u>		149. SIGNATURE OF 115TH LT. <u>John J. Brown</u>		150. SIGNATURE OF 116TH LT. <u>John J. Brown</u>	
151. SIGNATURE OF 117TH LT. <u>John J. Brown</u>		152. SIGNATURE OF 118TH LT. <u>John J. Brown</u>		153. SIGNATURE OF 119TH LT. <u>John J. Brown</u>	
154. SIGNATURE OF 120TH LT. <u>John J. Brown</u>		155. SIGNATURE OF 121ST LT. <u>John J. Brown</u>		156. SIGNATURE OF 122ND LT. <u>John J. Brown</u>	
157. SIGNATURE OF 123RD LT. <u>John J. Brown</u>		158. SIGNATURE OF 124TH LT. <u>John J. Brown</u>		159. SIGNATURE OF 125TH LT. <u>John J. Brown</u>	
160. SIGNATURE OF 126TH LT. <u>John J. Brown</u>		161. SIGNATURE OF 127TH LT. <u>John J. Brown</u>		162. SIGNATURE OF 128TH LT. <u>John J. Brown</u>	
163. SIGNATURE OF 129TH LT. <u>John J. Brown</u>		164. SIGNATURE OF 130TH LT. <u>John J. Brown</u>		165. SIGNATURE OF 131ST LT. <u>John J. Brown</u>	
166. SIGNATURE OF 132ND LT. <u>John J. Brown</u>		167. SIGNATURE OF 133RD LT. <u>John J. Brown</u>		168. SIGNATURE OF 134TH LT. <u>John J. Brown</u>	
169. SIGNATURE OF 135TH LT. <u>John J. Brown</u>		170. SIGNATURE OF 136TH LT. <u>John J. Brown</u>		171. SIGNATURE OF 137TH LT. <u>John J. Brown</u>	
172. SIGNATURE OF 138TH LT. <u>John J. Brown</u>		173. SIGNATURE OF 139TH LT. <u>John J. Brown</u>		174. SIGNATURE OF 140TH LT. <u>John J. Brown</u>	
175. SIGNATURE OF 141ST LT. <u>John J. Brown</u>		176. SIGNATURE OF 142ND LT. <u>John J. Brown</u>		177. SIGNATURE OF 143RD LT. <u>John J. Brown</u>	
178. SIGNATURE OF 144TH LT. <u>John J. Brown</u>		179. SIGNATURE OF 145TH LT. <u>John J. Brown</u>		180. SIGNATURE OF 146TH LT. <u>John J. Brown</u>	
181. SIGNATURE OF 147TH LT. <u>John J. Brown</u>		182. SIGNATURE OF 148TH LT. <u>John J. Brown</u>		183. SIGNATURE OF 149TH LT. <u>John J. Brown</u>	
184. SIGNATURE OF 150TH LT. <u>John J. Brown</u>		185. SIGNATURE OF 151ST LT. <u>John J. Brown</u>		186. SIGNATURE OF 152ND LT. <u>John J. Brown</u>	
187. SIGNATURE OF 153RD LT. <u>John J. Brown</u>		188. SIGNATURE OF 154TH LT. <u>John J. Brown</u>		189. SIGNATURE OF 155TH LT. <u>John J. Brown</u>	
190. SIGNATURE OF 156TH LT. <u>John J. Brown</u>		191. SIGNATURE OF 157TH LT. <u>John J. Brown</u>		192. SIGNATURE OF 158TH LT. <u>John J. Brown</u>	
193. SIGNATURE OF 159TH LT. <u>John J. Brown</u>		194. SIGNATURE OF 160TH LT. <u>John J. Brown</u>		195. SIGNATURE OF 161ST LT. <u>John J. Brown</u>	
196. SIGNATURE OF 162ND LT. <u>John J. Brown</u>		197. SIGNATURE OF 163RD LT. <u>John J. Brown</u>		198. SIGNATURE OF 164TH LT. <u>John J. Brown</u>	
199. SIGNATURE OF 165TH LT. <u>John J. Brown</u>		200. SIGNATURE OF 166TH LT. <u>John J. Brown</u>		201. SIGNATURE OF 167TH LT. <u>John J. Brown</u>	
202. SIGNATURE OF 168TH LT. <u>John J. Brown</u>		203. SIGNATURE OF 169TH LT. <u>John J. Brown</u>		204. SIGNATURE OF 170TH LT. <u>John J. Brown</u>	
205. SIGNATURE OF 171ST LT. <u>John J. Brown</u>		206. SIGNATURE OF 172ND LT. <u>John J. Brown</u>		207. SIGNATURE OF 173RD LT. <u>John J. Brown</u>	
208. SIGNATURE OF 174TH LT. <u>John J. Brown</u>		209. SIGNATURE OF 175TH LT. <u>John J. Brown</u>		210. SIGNATURE OF 176TH LT. <u>John J. Brown</u>	
211. SIGNATURE OF 177TH LT. <u>John J. Brown</u>		212. SIGNATURE OF 178TH LT. <u>John J. Brown</u>		213. SIGNATURE OF 179TH LT. <u>John J. Brown</u>	
214. SIGNATURE OF 180TH LT. <u>John J. Brown</u>		215. SIGNATURE OF 181ST LT. <u>John J. Brown</u>		216. SIGNATURE OF 182ND LT. <u>John J. Brown</u>	
217. SIGNATURE OF 183RD LT. <u>John J. Brown</u>		218. SIGNATURE OF 184TH LT. <u>John J. Brown</u>		219. SIGNATURE OF 185TH LT. <u>John J. Brown</u>	
220. SIGNATURE OF 186TH LT. <u>John J. Brown</u>		221. SIGNATURE OF 187TH LT. <u>John J. Brown</u>		222. SIGNATURE OF 188TH LT. <u>John J. Brown</u>	
223. SIGNATURE OF 189TH LT. <u>John J. Brown</u>		224. SIGNATURE OF 190TH LT. <u>John J. Brown</u>		225. SIGNATURE OF 191ST LT. <u>John J. Brown</u>	
226. SIGNATURE OF 192ND LT. <u>John J. Brown</u>		227. SIGNATURE OF 193RD LT. <u>John J. Brown</u>		228. SIGNATURE OF 194TH LT. <u>John J. Brown</u>	
229. SIGNATURE OF 195TH LT. <u>John J. Brown</u>		230. SIGNATURE OF 196TH LT. <u>John J. Brown</u>		231. SIGNATURE OF 197TH LT. <u>John J. Brown</u>	
232. SIGNATURE OF 198TH LT. <u>John J. Brown</u>		233. SIGNATURE OF 199TH LT. <u>John J. Brown</u>		234. SIGNATURE OF 200TH LT. <u>John J. Brown</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4773 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Crisfield</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Crisfield</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter T. Jones</u>		4. DATE OF DEATH <u>April 1 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15 1906</u>
9. AGE (In years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lee V. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Louise Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Stella Sigel</u>		Address <u>Salisbury Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. H. Coulbourn</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Deputy Medical Examiner</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sunburyridge</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Harmon</u>		ADDRESS <u>Crisfield Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
DATE <u>APR 6 '59</u>			

William H. Coulbourn, M. D.
DEPUTY MEDICAL EXAMINER
FOR SOMERSET COUNTY
WAS AUTHORIZED TO PERFORM? YES ☐ NO ☒

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04758

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Registrar of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dames Quarter</u>		c. LENGTH OF STAY IN lb <u>3 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Dames Quarter</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Marvin</u> Middle <u>Lee</u> Last <u>Lawson</u>			4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 9, 1959</u>		9. AGE (In years last birthday) <u>0</u> yrs. <u>3</u> Months <u>12</u> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland (Hosp.)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Mervin Corbin</u>			14. MOTHER'S MAIDEN NAME <u>Emma Whiten</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Emma Lawson - Dames Quarter, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/22/59</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-23-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dames Quarter Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Dames Quarter, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis B. Wilson</u>		ADDRESS <u>Princess Anne, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>

2082223XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1, Film G242,5-8-59 md
4765
CERTIFICATE OF DEATH

04759
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS X Somerset Ave.	
3. NAME OF DECEASED (Type or print) First William Middle E. Maddrix Last		4. DATE OF DEATH Month April Day 26, Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life—even if retired) Contractor & Builder		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George E. Maddrix		14. MOTHER'S MAIDEN NAME Angella Sterling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Olivia Maddrix, Crisfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 24, 1937 , to April 26, 1959 , that I last saw the deceased alive on April 26, 1959 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah M. Peyton		ADDRESS (Street, city or town, state) 33 W. Main - Crisfield	
DATE SIGNED 4/27/59		PHYSICIAN'S NAME (Type) m	
22a. BURIAL, CREMATION, or other disposition (Specify) burial		22b. DATE THEREOF 4/28/59	
22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Luman		ADDRESS Crisfield, Md.	
24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Knease	

04753

RECORDS OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04760

Reg. Dist. No.

4775

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 80 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS WARREN		4. DATE OF DEATH APRIL 1 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 - 15 - 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MASON		14. MOTHER'S MAIDEN NAME LAURETTA ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-5485	
17. INFORMANT THOMAS MASON, GIRDLETREE, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 min. 3 mt.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 481X Influenza - 3 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/1/59 10:40 AM to 4/1/59 19:59 that I last saw the deceased alive on 4/1 19 59 , and that death occurred at 4:25 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND DATE SIGNED 4/2/59			
ACTUAL SIGNATURE A. N. BARR, M.D. M.D.		PHYSICIAN'S NAME (Type) CRISFIELD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr 4, 1959	22c. NAME OF CEMETERY OR CREMATORY Mariners Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		24a. REC'D BY REGISTRAR APR 7 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE REGISTRAR, IT IS TO BE RETURNED TO THE REGISTRAR. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE REGISTRAR, IT IS TO BE RETURNED TO THE REGISTRAR. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE REGISTRAR, IT IS TO BE RETURNED TO THE REGISTRAR.

CERTIFICATE OF DEATH

1932

DATE OF DEATH

NOVEMBER 10

DECEASED

JOHN J. JACOB

WHITE

MALE

AGE 65

BORN 1867

AT BALTIMORE, MARYLAND

CAUSE OF DEATH

HEART DISEASE

CHOLESTEROL

THROMBOSIS

OF CORONARY ARTERY

AND

MYOCARDIAL INFARCTION

OF THE LEFT VENTRICLE

OF THE HEART

AND

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

AND

CHRONIC BRONCHITIS

AND

EMPHYSEMA

OF THE LUNGS

AND

CHRONIC RENAL DISEASE

AND

CHRONIC GOUT

AND

CHRONIC DIABETES

AND

CHRONIC HYPERTENSION

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CHRONIC ASTHMA

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CHRONIC COLIC

AND

CHRONIC CONSTIPATION

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CHRONIC URINARY CALCULI

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CHRONIC PROSTATITIS

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CHRONIC VENEREAL DISEASE

AND

CHRONIC

PLACE

JOHN J. JACOB

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4776

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04761

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lower Fairmount Maryland		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mitzi Middle Ann Last Parkinson		4. DATE OF DEATH Month April Day 5 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1958
9. AGE (In years last birthday) 0 yrs.		10. IF UNDER 1 YEAR Months 3 Days 11	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jack Phillip Parkinson		14. MOTHER'S MAIDEN NAME Julia Ellen Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Jack Parkinson, Upper Fairmount, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 18 Hrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. H. Johnson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. H. Johnson M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 6, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-6-59	
22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Wenona, Maryland - Somerset Co.	
23. FUNERAL DIRECTOR'S SIGNATURE L. S. Webster		24a. REC'D BY REGISTRAR Seal	
24b. REGISTRAR'S SIGNATURE Arthur L. Howard		DATE 4/6/59	

2179223XV2

FOR STATE
HEALTH DEPT

1778

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF EXAMINER: [illegible]
10. DATE OF EXAMINATION: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4766

CERTIFICATE OF DEATH

04762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 20 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEST MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle ANTHONY Last QUINN		4. DATE OF DEATH Month APRIL Day 9 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 10, 1897
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY CUTLERY MFG.	
11. BIRTHPLACE (State or foreign country) KENT COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES R. QUINN		14. MOTHER'S MAIDEN NAME JANE E. MULLIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 222-07-7068	
17. INFORMANT DANIEL J. QUINN--R.F.D. BOX 8--KENNEDYVILLE,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis acute DUE TO (c) Senil arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 47 , to April 9, 19 59 , that I last saw the deceased alive on April 9, 19 59 , and that death occurred at 1 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. G. Rawley M.D.		ADDRESS (Street, city or town, state) CRISFIELD, MD. DATE SIGNED 4/9/59	
PHYSICIAN'S NAME (Type) C. G. RAWLEY, M.D.		MAIN ST.--CRISFIELD, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR. 11, 1959	
22c. NAME OF CEMETERY OR CREMATORY LAMBSON CEMETERY		22d. LOCATION (City, town, or county) (State) GALENA, KENT COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS--CRISFIELD, MD.		24a. REC'D BY REGISTRAR APR 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01768

STATEMENT OF DEATH

01768

1

DECEASED

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DECEASED'S SIGNATURE

WITNESSES' SIGNATURES

DATE

TIME

PLACE

STATE

NAME

ADDRESS

CITY

STATE

DATE

TIME

STATEMENT OF DEATH

STATEMENT OF DEATH

1

01768

STATEMENT OF DEATH

STATEMENT OF DEATH

STATEMENT OF DEATH

STATEMENT OF DEATH

STATEMENT OF DEATH

STATEMENT OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film G241 4-23-59 et
4777
CERTIFICATE OF DEATH

04763
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Venton		c. LENGTH OF STAY IN 1b Life Time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle H. Last SMITH		4. DATE OF DEATH Month 4 Day 19 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/1877
9. AGE (In years last birthday) 82 81 yrs.		IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME HANDY SMITH		14. MOTHER'S MAIDEN NAME JULIA A. DESHIELDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT CECIE E. SMITH, PRINCESS ANNE, MD RT # 3		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arthritis INTERVAL BETWEEN ONSET AND DEATH 4 mos			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) h		20f. (City or town) (County) (State) h	
21. I certify that I attended the deceased from Jan 24 , 19 59 , to April 19 , 19 59 , that I last saw the deceased alive on April 15 , 19 59 , and that death occurred at 10:45 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Princess Anne, MD DATE SIGNED ELDON G. MARKMAN ACTUAL SIGNATURE Eldon G. Markman M.D. Princess Anne, MD PHYSICIAN'S NAME (Type) ELDON G. MARKMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/59	
22c. NAME OF CEMETERY OR CREMATORY Grace		22d. LOCATION (City, town, or county) (State) VENTON MD	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR. PRINCES ANNE, MD		24a. REC'D BY REGISTRAR DATE APR 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

CERTIFICATE OF DEATH

DECEASED'S NAME [Name]		SEX [Male/Female]	
DATE OF BIRTH [Date]		PLACE OF BIRTH [Place]	
DATE OF DEATH [Date]		PLACE OF DEATH [Place]	
TIME OF DEATH [Time]		CAUSE OF DEATH [Cause]	
MEDICAL HISTORY [History]		OCCASION OF DEATH [Occasion]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF JUDGE [Signature]	
SIGNATURE OF CLERK [Signature]		SIGNATURE OF NOTARY [Signature]	

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner or other person who has examined the body, or by the family or other person who has knowledge of the facts. It is to be filled out as soon as possible after death, and before the body is buried or cremated. It is to be filled out in duplicate, one copy to be retained by the person who filled it out, and the other copy to be sent to the State Department of Health.

CERTIFICATE OF DEATH

04764
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Crisfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Crisfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Delware Middle Tyler Last Tyler		4. DATE OF DEATH Month April Day 30 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min.	IF UNDER 24 HRS. Months 80 Days 80 Hours 80 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Tyler		14. MOTHER'S MAIDEN NAME Harriet Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213 -09-4923	
17. INFORMANT Mrs. Sally Tyler, Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Nephritis - leukemia DUE TO (b) Antenatal sclerosis DUE TO (c) White matter		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 29 , 19 59 , to Apr. 30 , 19 59 , not I lost saw the deceased alive on Apr. 30 , 19 59 , and that death occurred at 3:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah M. Peyton M.D.		ADDRESS (Street, city or town, state) 3341. Zwaan DATE SIGNED 5/4/59	
PHYSICIAN'S NAME (Type) Sarah M. Peyton		Crisfield	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 5/3/59	22c. NAME OF CEMETERY OR CREMATORY Asbury	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Samuel L. Luman		24a. REC'D BY REGISTRAR DATE MAY 6 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Luman	
ADDRESS Crisfield, Md.			

01784

CERTIFICATE OF DEATH

4773

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04765
Reg. Dist. No.

4779

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY SOMerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne R. F. D.		c. LENGTH OF STAY IN 1b 5 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, R. F. D.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Perry Vaughan				4. DATE OF DEATH April 14 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1885		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Norfolk Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jessie Vaughan				14. MOTHER'S MAIDEN NAME Mary ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 231-09-0691		17. INFORMANT 1514 Bradley Avenue Elizabeth Cooper, Camden N. J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Asthma 241 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c)						INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R. H. Johnson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R. H. Johnson M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		April 16, 1959	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) Princess Anne, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Johnson Jr				24a. REC'D BY REGISTRAR DATE APR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

41785

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

41785

NAME - LAST
FIRST

MIDDLE

AGE - YEARS

SEX - MALE / FEMALE

DATE

TIME

PLACE OF DEATH
STREET

CITY

STATE

DEATH

CAUSE

ICD-9 CODE

ICD-9 CODE

DATE OF BIRTH

PLACE OF BIRTH

STATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH
STREET

CITY

STATE

DEATH

CAUSE

ICD-9 CODE

ICD-9 CODE

DATE OF BIRTH

PLACE OF BIRTH

STATE OF BIRTH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4780 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 5, Film G242, 5-8-59 md

04766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Edward McCready Hospital			d. STREET ADDRESS 331 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Leon Middle Whittington Last Whittington			4. DATE OF DEATH Month April Day 30 Year 1959		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1907	9. AGE (in years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaford Worker		10b. KIND OF BUSINESS OR INDUSTRY Marion Station		11. BIRTH PLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Sherman Whittington			14. MOTHER'S MAIDEN NAME Gertrude Jones		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-01-2373		17. INFORMANT Harriett Whittington - Crisfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO (b) Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH William H. Coulbourn, M.D. DEPUTY MEDICAL EXAMINER FOR SOMERSET COUNTY, MD.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR INJURY GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 4-30 19 59 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Crisfield Somerset	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W. H. Coulbourn M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 30 - 1959	
EXAMINER'S NAME (Type) W. H. Coulbourn M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1959		22c. NAME OF CEMETERY OR CREMATORY John Wesley M.E.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Hard		ADDRESS Marion Sta., Md.		24a. REC'D BY REGISTRAR May 5 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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1928-1929

of the ...

Received of John Wesley M.E. Mission Socy \$100.00

Charles H. Johnson, Jr.